Erotomania Revisited: Thirty-Four Years Later

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Erotomania (also known as De Clerambault's syndrome) is usually described as a rare delusional syndrome that characteristically involves a woman who believes that a man, typically of higher social, economic or political status, is in love with her. Two cases are reviewed here that have been followed for over 30 years, making these some of the longest, single-case longitudinal studies yet reported.

De Clerambault's syndrome remains a ubiquitous nosological psychiatric entity with uncertain prognosis. In 1980, we reported in this journal one woman diagnosed as having erotomania. At that time, she had been followed for approximately eight years. She has now been studied for over 30 years.

In De Clerambault's original work, as reported by Enoch and Trethowan, a woman whose chronic, erotic delusion remained unchanged was followed for 37 years. Despite some psychological advances, our original patient, like De Clerambault's, has remained essentially entrapped by her psychotic thought disorder and erotomania.

A thorough review of the literature to date was contained in our 1980 article and so, to avoid repetition, we refer the interested reader to that reference.[1] At this time, the original patient's history will be presented along with the course of her disorder and treatment implications. Secondly, another patient will be presented and her case reviewed. Finally, we will argue that this disorder is not as rare as has been claimed and call for the continued recognition of this syndrome as its own entity despite recent opinions that such use be discontinued.

Key words: erotomania ■ De Clerambault's syndrome

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In this paper, two cases will be reported. They have been followed for 33 years and over 40 years, respectively, making them among the longest followed single cases yet reported. Despite various treatment modalities, both patients have remained essentially entrapped by their psychotic thought disorders and erotomanic delusions. These two cases are examples of the fixed (as opposed to the recurrent) form of erotomania. First, there will be a brief review of the concept of erotomania followed by a discussion of the diagnostic and therapeutic implications of the syndrome. Hopefully, this will stimulate interest in this often unrecognized mental disorder.

De Clerambault's syndrome, usually called erotomania, was first described by G.G. De Clerambault in 1942. The syndrome characteristically involves a young woman with the delusion that a man whom she considers to be of higher social or professional standing is in love with her. She develops an elaborate delusional process about this man, his love for her, his pursuit of her and his total commitment to her. This syndrome may persist for a period of a few weeks in the recurrent form and may be replaced by a similar delusion about another man. In the fixed form, it may persist for several years. The longest reported unimproved case is 37 years. It may also occur in men. However, men are often stalkers and may become violent.

Case 1

In April 1971, the senior author began seeing a 21-year-old Caucasian female who presented with a very intense delusional system. She was well dressed and presented herself in a very dignified manner. She talked in the manner that would give the impression that she was quite well adjusted and free of psychotic delusions. However, as she began to talk about her intended boyfriend, it was obvious that there were delusions present. She began to talk about him as if they were engaged in a romantic relationship. However, they had never had a date and she had only seen him in class. She went on to say that she knew he loved her,

and she was attracted to him because of his extreme love for her. In other words, she loved him because he loved her so much. She realized he was empty without her and was pursuing her, but enemies were preventing them from uniting. The enemies included a number of people: people in her family, her classmates, neighbors and many other persons who were plotting to keep them apart. She knew that her conclusions were accurate because he would send messages to her proving his love. These messages would often present themselves as the license plates on cars of a certain state, the color purple and other indications that she received from the environment that proved to her that he loved her. She also indicated that he gave meaning to her life, and she was certain she gave meaning to his despite the fact that they were not yet together. She also said that she would not relate to any other man because, if so, she would be unfaithful to him. She insisted that she would wait for him eternally. She also indicated that the world knew about this—even the president of the United States and other important people were very much aware of their love for each other. He provided meaning to her life that she did not have before and if she did not have him her life would have no meaning. During the course of three or four years, these delusions persisted.

In addition to the persistence of the delusions, she developed additional delusional ideas. One was that he visited her at night for many years, married her and impregnated her, and that she had given birth to a large number of children. These children had been taken away from her by her parents and her psychiatrist and given up for adoption without her permission. She is very angry about that.

There were also times during the course of follow-up in the initial three or four years that she would become violent toward her family if on a given occasion, such as a holiday, he did not come. This was especially true during the early years. There was also a period of time in which she would not leave the house and would confine herself to her parents' or sister's home for months at a time for fear that someone (i.e., one of the enemies) would harm her.

She was hospitalized in 1978 for a short period of time and given electroconvulsive therapy. The result of that was a very brief resolution of her delusive process. A review of that would reveal that she was only relatively free of the delusions for about two or three weeks after treatment. But after that, they returned and have continued. Various antipsychotics over the years have been helpful in controlling the extremes of her agitation; her potentially dangerous behavior has minimized. However, the erotomanic delusions have continued unchanged throughout this period of time.

In view of the fact that this young lady has not exhibited the majority of the symptoms of schizophrenia and has not had more bizarre delusions other than those described above, she has been able to function in the community and her home with some degree of success. Her diagnosis is delusional disorder persecutory type.

Case 2

In the mid-1960s, approximately 1965, a young African-American lady in a psychotic state was admitted to a psychiatric hospital. She was exhibiting all of the symptoms of schizophrenic disorder, paranoid type, including autistic thinking and extreme ambivalence, particularly toward the members of her family; inappropriate affect; loose associations with delusional thinking; incoherent speech; delusions of persecution; sometimes grandiose delusion; auditory and visual hallucinations; marked illusions; extreme elusions; and occasional bizarre behavior.

She was an attractive young lady who had taken an art course in college and had become enamored with a professor, thinking he was in love with her. The young man was married. She refused to accept the fact that he was married. She would send him letters, cards and flowers. She would visit his home and make an effort to enter. She did not accept the fact he was married and indicated he was pretending to be married but he knew that he loved her. He took her to court on several occasions, and the judge ordered her to cease that behavior but she did not cease it for several years. She pestered him endlessly over a prolonged period of several years and may have threatened to terminate his marriage.

During that time, she was admitted to the hospital on several occasions for recurring episodes of schizophrenia. For many years, she was followed by another psychiatrist, who was employed by the psychiatric hospital where she was a patient on numerous occasions. She also had many episodes of psychotic behavior in addition to her delusions about this man, but the delusions continued through the years. There were times that she would confine herself to her home because, as the other patient had done, she was afraid that enemies were threatening her life. Again, they were threatening her life because of her love for him, and they were plotting to keep them apart. She was very certain that he loved her and thought she had demonstrative evidence of same.

Though she was not the patient of the senior author, she and the senior author had several encounters in that he worked for the state for several years, made several trips to the hospital where she was housed and saw her in the hospital many times. She also, on occasions, would write letters to the senior author about issues about which she was concerned regarding the state mental hospital system.

She was a very accomplished artist and did many self-portraits as well as portraits of others, which were certainly quite impressive. On our last encounter with her, she had been followed at that time for approximately 30 years. The encounter occurred because she wanted to have one final opportunity to confront her fantasized lover and have him tell her once and for all how he felt. She indicated that she would accept whatever the results were of that encounter. The young man, of course, was not willing to meet with her but talked on the phone to the senior author and one of our other authors who was following her. He indicated, as he always did, that he was never interested in her, was not interested in her now and had wished for this period of 30 years that she had never become a part of his life in the manner in which she had thrust herself upon him. We shared that with her and did not know how she would respond. My impression is that she continues to have fantasies about him and have desires that he would finally come to his senses and accept her as his wife.

She was treated, as many schizophrenic patients are, with antipsychotic medications. The extremes of her psychotic disorder on a given occasion, as described above, certainly responded to the medication. However, her erotomanic systems did not respond to medication. The medication has only served to minimize the extremes of her behavior associated with her erotomanic delusions. She has now been followed for at least 40 years.

DISCUSSION

Erotomania is a relatively uncommon and misunderstood disorder characterized by the presence of a persistent erotic delusion. The disorder's components, as summarized by Taylor et al.,[2] are:

- the presence of a delusion that the individual (usually described as a female) is loved by a specific man;
- the woman has had little or no contact with the man;
- the man is unattainable in some way, because he is already married or because he has no personal interest in her;
- the man is perceived as watching over, protecting or following the woman;
- despite the erotic delusion, the woman remains chaste.

Various authors have described and named this syndrome prior to its official recognition. Rather[3] has traced its origin back to Hippocrates. He also traced its origins back to the Parisian physician Bartholomy Pardoux (1545–1611), who discussed the pathology of love in his book, *Disease of the Mind*, and distinguished between uterine furors (nymphomania) and insane love (erotomania). It was also referred to by Jacques Ferrand in 1623 in a treatise on malades d'amour or melancholie érotique.[4] Sigmund Freud, in 1911, called the illness erotomania, meaning "too much love." G.G. De Clerambault, in 1942,[5] classed the symptoms into the disorder he referred to as "psychose Passionelli." In 1971 and 1977, M.V. Seeman further studied the illness and subsequently called them: phantom lover syndrome, psychotic erotic transference reaction and delusional loving.[6]

There is some overlap as to the form describing the love object, in accordance with Seeman's study. The phantom lover may be someone who does not exist, or it may be someone who once existed but has died or relocated. In this instance, the death or departure is delusionally denied. It may be a total stranger, someone unknown or someone with whom the patient never conversed. A person with whom a relationship was previously established but with whom the person no longer or has never had contact with could be the love object. This is noted in the first case presented in which the first patient chose a classmate, an individual in which formal interaction had not occurred. She, in fact, had rarely seen him. Doctors, teachers and lawyers have also been incorporated into patient's delusions, as their intentions to assist the patient are misinterpreted.

Nevertheless, the patients may bring chaos into the lives of their victims. A grotesque drama often ensues when erotomanic patients act on their delusions, relentlessly bombarding their victims with telephone calls, letters, gifts and visits. Persistent surveillance and stalking may occur. After repeated professions of love and advances are unrequited, these patients may become dangerous, as resentment and rage are mobilized in response to perceived rejection by the love object. Although actual physical and sexual assaults are uncommon, these patients may inflict enormous psychological and social disruption as a consequence of their merciless harassment and pursuit over a period of many years. Victims may be reduced to living in an unrelieved state of siege.[7] Motivation for the stalking behavior has been found to emerge from a desire to forge an intimate relationship with the victim. Purcell et al.[8] found that in their sample, one-quarter of female stalkers manifested erotomanic delusions, with the remainder hopeful that their pursuit would culminate into a relationship.

The nature of the hoped-for intimacy, although usually romantic or sexual, also encompassed such aspirations as establishing a friendship or even a mothering alliance with the victim. In reference to the second case, the patient acted on her delusion by

repeatedly contacting the object of her affection. The results of a study by Menzies et al. suggests that the risk and extent of actual physical harm posed by erotomanic subjects may be less than by other categories of stalkers.[9]

There are numerous theories as to the etiology of this illness. It is important to mention that erotomania is not uniquely associated with any specific illness. It is sometimes found with psychiatric disorders such as bipolar affective disorder,[10] schizophrenia,[11] senile dementia,[12] meningioma, alcoholism[13] or even orchiectomy.[14]

One theory involves a neuroscientific basis, in which the disorder is actually a form of schizophrenia with a neurochemical imbalance. In this instance, attempts to restore the balance through dopamine and serotonin blockers are being made. Very recently, one study demonstrated an association between the onset of erotomania and the use of high doses of the antidepressant venlafaxine. Although venlafaxine has primary effects on the 5-hydroxytryptamine and norepinephrine uptake, repeated administration was found to also affect the dopamine system.[15] The increase in the responsiveness of postsynaptic dopamine 2/dopamine 3 receptors in the mesolimbic system with high doses of venlafaxine could be responsible for the emergence of a psychotic illness.[16]

Another theory is that of a genetic basis. Here, it is postulated that a person may be genetically predisposed, hence, the disorder appears in successive generations.

Subjects in a study by Kennedy et al.[17] reported strong family histories of psychiatric disorders, with three having a first-degree relative with a history of a delusional disorder—two of schizophrenia and one of psychotic bipolar affective disorder. One subject in this series has a history of morbid jealousy and erotomania in life and a maternal history of delusional morbid jealousy. Another subject's mother had a history of morbid jealousy, and one subject's sister also had a history of erotomanic delusions. Morbid jealousy and erotomania occurring in successive generations have been described and explained psychodynamically as being due to lack of basic trust.[18]

Various psychodynamic formulations have been offered. Enoch et al.[19] believed that erotomania evolved out of the search for a safe and unattainable eroticized father figure and the need to ward off homosexual impulses. It was Freud's[20] belief that erotomania in the male was a variant of paranoia resulting from denial, displacement and projection. Through this, a formula evolves: "I do not love him; [rather] I love her because she loves me." The sex of the patient does not seem to influence the structure of the delusions. Hence, for women, using Freud's formula, this would be transformed into "I do not love her; I love him because he loves me." Cameron[21] views erotomania as self-love that has been denied and projected onto a man. Raskin and Sullivan[22] view erotomania as an adaptive function, warding off depression and loneliness following a loss. Hollender and Callahan[23] suggest that the erotic delusion is the result of an ego deficit shaped by an intrapsychic struggle of feeling unlovable following a narcissistic blow. Feder[24] views romantic love, behind which lies the drama of an ontogenetic earlier phase of life elaborated in psychosis. He further relates that under conditions of regression, it is an attempt at restoration of the earlier blissful union with the mother figure.

Still another postulation is that environmental, psychological, pharmacological and physiological factors may often trigger a predisposed person into developing erotomania.[25] Finally, it has also been postulated that learning through the media (television, radio, books, etc.) has influenced the development of this particular type of delusion. This is the "Cinderella syndrome", the young girl's fantasy of Prince Charming.

The incidence of erotomania is not known. One reason may be that it is often not recognized as a syndrome and becomes classified under a larger psychiatric category. Also, not all instances of De Clerambault's syndrome come to psychiatric attention. Typical cases, however, have been described in newspaper accounts and court proceedings. Several cases are described in the scientific world literature. According to Pearce[26]:

> *... with the revolutionary sociocultural changes that have taken place in the Western world over the last half-century, with the far greater freedom of expression in sexual matters ... it seems likely that this particular syndrome will become an even greater rarity than it is at the moment.*

However, this belief is doubtful, due to the reports of new cases and the increasing rise of interest in the illness.

More authors agree with De Clerambault that there are two clearly distinguished types of erotomania. Some have altered the nomenclature and added other criteria for the differentiation. De Clerambault[5] described two forms of his syndrome, pure or primary erotomania, and secondary of recurrent erotomania. In the pure form, the delusion exists alone. There are never any hallucinations nor global or absurd megalomaniac conceptions. No "insanity" is present in this form, yet the onset is sudden. The illness is clearly defined, the course chronic. In the secondary form, the disorder is associated with oth-

er psychoses—most commonly, paranoid schizophrenia. It is often seen with a wide range of persecutory themes, ideas of grandeur and mysticism. The onset is gradual, the illness is diffuse. There is also the possibility of a future different love object and transference. In the presented cases, both women possessed the primary form of erotomania with sudden onsets of illness superimposed on preexisting psychoses. The illnesses were also diffuse with delusions of persecution and ideas of grandeur.

Seeman[27] divided her patients into two groups: the fixed and the recurrent. Patients in the fixed group were more seriously ill. The delusion remained constant and chronic despite treatment. The disorder appeared to occur in poorly integrated women who were dependent, timid, unpredictable and had few heterosexual experiences. These women seemed to feel inferior to others. Each selected a lover who was viewed as someone who was superior to them from a socioeconomic-cultural vantage point. More often, they were diagnosed as schizophrenic. The delusion appeared to serve as a defense against low self-esteem, sexuality and external aggression.

On the other hand, patients in the recurrent group were less psychiatrically ill. The delusions were recurrent, short-lived and intense. The illness occurred in some who were characterized as healthier, aggressive, impulsive and more sexually active. These women selected lovers who were powerful and prominent. Their delusions served as a defense reaction against homosexual doubts and feelings of competitiveness or resentment and may have been an attempt to incorporate power and self-image.

In the presented cases, both patients fell into the fixed group. They are seriously psychiatrically ill. The onset of erotomania was sudden, and their delusions have basically remained unchanged despite treatment. Both women were shy, introverted, detached and had few interpersonal skills as children and young adults. Both women chose ordinary lovers, which too, is consistent with Seeman's fixed group.

Traditionally, the prognosis and response to treatment are very poor. A majority of primary erotomanic patients appear to respond to low-dose neuroleptics and have a better outcome than do patients with other psychotic disorders.[17] Different neuroleptics have been used with reports of various levels of effectiveness. Pimozide, a diphenylbutylpiperidine widely used in Europe, Britain and Canada, is one of the more recent antipsychotics cited as achieving successful results in cases of monodelusional disorder.[28,29] A study by Kelly et al.[30] demonstrated successful treatment of erotomania with risperidone, an atypical antipsychotic medication. Risperidone seems to have a more attractive side-effect profile in the dosage used (<6 mg per day) when compared to conventional agents used traditionally in monodelusional disorders. In the patients presented, multiple neuroleptics were employed with some relief of symptomology, but no lasting effect.

Electroconvulsive therapy is another treatment modality noted for temporary effectiveness. ECT was implemented for the first patient, with some short-term relief. It was considered but not attempted with the second patient. Psychotherapy remains to be another treatment option. It appears that supportive therapy provides better benefit than some insight orientation. Confrontation should not be used, as these patients are often extremely paranoid and may incorporate the respective therapist into their delusion while becoming assaultive. Psychotherapy in the form of supportive therapy was tried for both women. On one occasion, when all treatment modalities had failed, a confrontational approach was used for the first patient. In this instance, a telephone call was made to the fantasized lover in the hope that hearing him state that he had no plans to return and marry her would encourage her to question her delusional ideas. The young man expressed that he vaguely remembered her as a quiet, reserved classmate but had long since forgotten about her and that he had no intentions to marry her. At the termination of the call, the first patient rationalized that the speaker was not the alleged lover but an actor/impersonator, as the lover would have never said such a thing. Regarding the second patient, a meeting transpired with the alleged lover and the psychiatrist with the hope that some form of assistance could be offered for this patient. The second patient, in turn, incorporated the meeting into her psychotic thought process and stated that if her lover attempted suicide, it would be on the shoulders of her psychiatrist.

Despite the fact that these patients have not improved in the period of >30 years and may not improve in reference to the erotomanic delusions that they possess, many things have been done for the patients which have been helpful. Both of them have been able to remain in the community for most of their lives. The first patient has remained in the community almost her entire life with the exception of a short period of time in which she was hospitalized to receive electroconvulsive therapy. Antipsychotic medication has been helpful in controlling some of the extremes of the psychotic delusional system. The medication has controlled that behavior that may otherwise have been dangerous. Consequently, they have been able to function in the community. Both patients have worked for periods of time and have functioned relatively well for the short periods of time they have worked. Neither has worked longer than a year at a time, but both of them have had jobs that have lasted at least several months to

a year and often ended because the person with whom they worked became enemies associated with the erotomanic delusion. Also, a great deal of family therapy has been done. The first patient has a twin sister, a mother, a father who is now deceased, a younger sister, and two nieces who are children of the younger sister. She has been able to live with the mother (and father before he died), help with babysitting the younger sister's children and help limitedly her mother in her home in terms of the daily responsibilities of taking care of a home. The medication and the family therapy and the psychosocial and environmental therapy, which the family has provided under the guidance of the senior author, has been helpful to her and to her family despite the fact that her delusional system remains. In reference to the second patient, she was also provided a similar psychotherapeutic family and environmental therapy program. She has lived with her parents and her young son until he became an adult. She was able to participate in the care of her son, to work with him and her mother in terms of the household and maternalist duties and between episodes in the hospital function as a minimally effective person in the household and in the family. Obviously, individual psychotherapy has not been helpful with these young ladies in reference to their erotomanic delusional systems.

This disorder is often overlooked for several reasons. Among these is the fact that the disorder is often associated with more well-known disorders in psychiatry such as schizophrenia, bipolar disorder, major depression, delusional disorder or another form of psychosis (such as psychotic depression, etc.). Also, the treating psychiatrist is often focused on the primary disorder and sees the erotomanic syndrome as being a symptom of the disorder, which it is. However, he or she may not always recognize that erotomania is a syndrome in and of itself. Second, the disorder is relatively rare and many psychiatrists do not see it often or do not recognize it when they see it. Third, the disorder may have occasionally appeared as a recurrent disorder such that the patient may have symptoms of erotomania for a few months or years, and these symptoms may disappear depending on the circumstances under which she developed the delusion and the relationship she had with the intended lover may have changed. This is called the recurrent form.

Finally, the adjustment of socio-environmental factors may be a very beneficial treatment alternative. One of the theories is that the delusion supports an ego that has been hurt and that often times seems to follow a stressful romantic relationship. In this case, in order to remove a delusion, it needs to be replaced with something positive. Referring to the cases presented, a socio-environmental therapeutic process was attempted. It was hoped that the triumph of overcoming given challenges to the women would have led to amelioration of their delusions. The first patient was given a position as a medical technician in a library. However, due to her impaired functioning level, she was unable to continue employment. The second patient was given a job as an art therapist for psychiatric patients. She, in turn, claimed to mistrust and have difficulty identifying with the staff in the role of caregiver.

Munro reported in 1985 the successful treatment of two patients with the primary form of erotomania, with pimozide.

For many years, we have considered pimozide as a potential therapeutic agent for our patients, but it has not yet been approved by the Food and Drug Administration for use in psychosis. It is only approved for use in the disorder called Tourette's syndrome. For that reason and others, we have not used pimozide. Pimozide is an extremely potent and powerful antipsychotic, which has many side effects and can be exceedingly dangerous. Not only are there side effects, such as extrapyramidal syndrome, it can also very likely cause tardive dyskinesia. We are not aware of any American authors who describe the successful treatment of the primary form of erotomania with pimozide.

The recurrent or secondary form of erotomania, which is described as a disorder that may reemit spontaneously or with treatment, has been known to respond well to various forms of psychotherapies, and group, family and individual therapies as well as antipsychotic medication. The author has had patients with secondary or recurrent erotomania who have responded spontaneously and/or with use of above-named therapies.

Kennedy et al., in 2002, also described the complete resolution of primary erotomania in two cases where patients were given low doses of antipsychotics, such as risperidone or trifluoperazine. Again, this was a group of British physicians who reported this finding.

Remington and Book, in 1984, in the *American Journal of Psychiatry* reported fairly complete resolution of the erotomanic syndrome in a patient with bipolar disorder with lithium. However, this was also a group of Canadian psychiatrists, and they did not make clear whether these patients were suffering from primary or secondary erotomania, which is known to reemit either spontaneously or with medication.

They further indicate that patients with erotomania who have bipolar disorder are more likely to have a recurrent form of erotomania, and this form of erotomania would improve when the bipolar disorder is aggressively treated and placed in remission. This is an experience that the senior author has had in following patients with recurrent forms of erotomania, particular-

ly with those who may have delusional disorders, formerly called paranoid disorders, i.e., those who do not have schizophrenia as a primary diagnosis.

Kennedy et al. reported in 2002 that delusions partially resolved in primary erotomanics with depot antipsychotics. Two cases resolved completely. In conclusion, two patients who demonstrate the syndrome of erotomania have been presented. Hopefully, there will be future reports of this syndrome. It is anticipated that an increased awareness and understanding of this illness will assist in the recognition of patients affected, opening doors for future development of new treatment modalities.

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